Critical thinking scenario

Contents

Introduction

The case study that has been provided for the purpose of this research paper is about Mrs. Audrey Smith, a 75 year old woman who was brought to the Emergency department after she was found lying down on the kitchen floor by her neighbor. The patient had tripped over her dog and had been diagnosed with a fracture of the neck of the femur, soft tissue injuries, bruising to her left shoulder and a small hematoma on her left forehead. The GSW scale reading is 14. The patient's past medical history is indicative of AF, hypertension, L-CVA, T2dm GORD, osteoporosis, hysterectomy in the year 1995 and has been suffering from depression since the year 2011. The paper will analyze and critically access the nursing interventions that are required for the patient's safety, health and hygiene. The patient is suffering from a

fracture of the neck of the femur. It is a common injury that takes place in the elderly. Femoral neck fractures can either be extra capsular or intracapsular in nature. When the fracture is between the joint and the capsule it is known as an intracapsular fracture. These are very problematic as there is an interruption in the blood supply to the femoral head and can cause tissue necrosis. While the extra capsular fractures take place outside of the capsule. Here the blood supply is less compromised and operative fixation is mainly dependent upon the kind of fracture that has been caused.

Answer 1.

Needs	**Nursing intervention**	**Rationale**	**Desired outcome**
Safety	1. Maintain a neutral position of the hip that has been fractured. 2. Usage of a trochanter roll. 3. Put a pillow between the patient's legs.	1. Helps to reduce and prevent stress where the site has been fixed. 2. Helps in reducing external rotation. 3. Helps in lending support to the patients legs and stops adduction from	The patient makes use of the positioning. Uses pillows positioned between the legs while turning sides.

	4. Use a trapeze 5. Supervision for usage of ambulatory aids.	taking place. 4. Helps in strengthening the muscles of the shoulders and arms that are imperative for ambulatory aid. 5. Helps to prevent any injury from unsafe usage.	Makes use of the trapeze. Takes part in an exercise schedule. Makes use of ambulatory aids.
Hygiene and comfort	Take care to keep the patient away from moisture as it is the breeding ground of infection. The patient should be cleaned daily. Sides of the patient should be turned frequently as well. The catheter tubes needs to be cleaned to prevent any infection.	Helps in lowering the chances of occurrences of 1. Pressure ulcers. 2. Septic infections. 3. Urinary tract infections.	The patient is healthy and free from any type of post operative infection.

Nutrition	Monitor the intake of food and vitamins that are eaten by the patients. Follow a tailor made plan that keeps in mind the dietary requirements of the patient. It is essential to keep in mind that the patient is anorexic and can face malnutrition as a post operative complication (Jung, Trivedi, Grabowski & Mor, 2015).	In order to ensure the patient recovers fast and has optimum healing it is essential to consume minerals and vitamins along with a well balanced diet plan.	The patient is healthy, vitamin D levels are acceptable. Heals well and is in the final stages of recovery.
Elimination	1. Monitor the intake and output. 2. Avoid using a catheter.	1. Having an adequate intake of fluids helps in marinating hydration and lowers the risk of having urinary stasis. 2. Sources of a bladder infection.	The intake and output should be plenty and the patient shows voiding patterns that are normal. There is no evidence of a urinary tract infection.

	3. Perform intermittent catheterization for urinary retention.	3. Helps in emptying the bladder and reduces the occurrence of Urinary tract infections as well.	
Activity levels	Monitor the range of mobility of the patient. Response to commands	Helps in gauging the range of defect in motion. Analyzing the neuromuscular functioning of the patient (Jung, Trivedi, Grabowski & Mor, 2015).	The patient should be alert and not in a delirium and is quick in responses (Burns et al., 2014).
Psychosocial needs	1. Encourage the patient to express their fears and concerns while discussing the fracture (Resnick et al., 2016).	1. Expressing their thoughts and concerns lowers the anxiety and stress levels. 2. Coping mechanisms help in reducing fear and stress.	The patient demonstrates feels of concern for his injury and wants to help in the process of planning.

	2. Support them while using coping mechanisms. 3. Contact social services if the need arises. 4. Encourage the patient to take interest in the planning process,	3. Anxiety can be due to stress of finances and other problems. 4. Taking part in planning care activities gives a sense of control.	

Answer 2.

The patient Mrs. Audrey has a past history of the following:

a. AF
b. Hypertension
c. L-CVA in the year 2008
d. T2DM in the year 2008
e. Osteoporosis
f. A total hysterectomy in the year 1995
g. Depression since the year 2011

The patient needs to undergo a surgery to fix her fracture. However one of the most imperative factors to take into consideration is the risk of developing a urinary tract infection as the patient is prone to them along with moderate constipation and development of pressure ulcers. The patient has a history of

anorexia hence care needs to be maintained that the patient does not become nutrient deficient after the surgical procedure takes place as it could cause the hemoglobin levels to reduce further. Mrs. Audrey suffers from osteoporosis thus her femoral fracture outs her at a higher risk for having a future fragility fracture. Hence secondary prevention needs to be made on top priority. Bone strength needs to be maintained and the process of bone loss needs to be slowed own. Hence it is suggested that a complete serum and urine protein electrophoresis test is carried out along with lifestyle changes, cessation of alcohol consumption. The patient has been consuming Vitamin D 1000 mg per day to treat her deficiency along with a calcium substitute to treat her bone loss. One of the major risks that the surgery can have on the patient is constipation and it can cause pressure to build up on the surgical site as the patient is already suffering from constipation and moderate urinary incontinence extra care and precaution needs to be maintained so that these factors do not turn into life threatening scenarios for the patient (Sheehan, Sobolev, Chudyk, Stephens & Guy, 2016). The patient is also on medication for the treatment of hypertension and has underdone treatment for AF and L-CVA in the year 2008 as well. The patients underlying conditions can create a negative impact for the post surgical care that needs to be provided to Mrs. Audrey. Furthermore the patient has been a widow and is living alone with minimum interactions with members of the community and is thus suffering from depression. Healing post the surgery can be complicated if the patient is depressed, hence care needs to be taken that the patient is provided motivation so that she can become mobile soon.

Answer 3.

Medication	**Indication for use**	**Nursing implication**	**Effect on patient**
Digoxin 62.5 mcg OD	For patients suffering from ventricular rate control in patients with chronic atrial fibrillation.	acute myocardial infarction Adams-Stokes syndrome AV block, bradycardia, cardiomyopathy, cor pulmonale, hyperthyroidism,	The patient could suffer from an acute myocardial infarction ("Digoxin (digoxin) dose, indications,

		hypothyroidism, hypoxemia, myocarditis, myxedema, pulmonary disease, sick sinus syndrome	adverse effects, interactions... from PDR.net", 2017).
Warfarin 2 mg OD	Prophylaxis and treatment of: Venous thrombosis, Pulmonary embolism, Atrial fibrillation with embolization. Management of myocardial infarction	Severe liver or kidney disease; Uncontrolled hypertension;	Decreases risk of death, Decreases risk of subsequent MI, Decreases risk of future thromboembolic events. Prevention of thrombus formation and embolization after prosthetic valve placement.
Coversyl 5 mg OD	Heart failure • Diabetic nephropathy	Hypersensitivity to drug or other ACE inhibitors • Hereditary or idiopathic angioedema	dizziness, fatigue, headache, insomnia, sleep disorder, weakness, asthenia, drowsiness, vertigo, depression, paresthesia
Vitamin D 1,000 units OD	Used for lack of vitamin D in the body	Bones become vulnerable to fractures.	Osteoporosis.

Metformin 500 mg BD	Diabetes and hypoglycemia.	Monitor for decreased liver function and a predispose to lactic acidosis.	risk of lactic acidosis
Esomeprazole 40 mg OD	GERD/erosive esophagitis	Bone fracture Nausea hypertension	Hypersensitivity
A. Efexor 150 mg OD B. Caltrate 600 mng OD C. Mylanta 15-30 mls prn	a. Depression, generalized anxiety disorder; social anxiety disorder. b. Caltrate is used for preventing low calcium levels. c. Gas/ heartburn	a. Hypersensitivity b. Can cause constipation c. Hard stools (constipation) and loose stools (diarrhea).	Renal and hepatic impairment, renal failure; anorexia nervosa ("VENLAFAXINE", 2017) elevated intraocular pressure, acute closed-angle glaucoma ("Caltrate 600+D: Indications, Side Effects, Warnings - Drugs.com", 2017) cardiac disorders recent MI, heart failure; hypertension; hyperthyroidism; concomitant administration with CNS drugs, CNS depression; history of

			seizures or seizure disorders;

Answer 4.

Prior to the surgery as a nurse it is very essential to prepare the patient for the surgery that is to take place. The patient needs to be prepared psychologically as well as physiologically for the surgical procedure that is to take place during the preoperative phase. The nursing interventions that take place are aimed to treat and at the same minimize the medical conditions that preexist. It is imperative as a nursing professional to make certain that the patient is provided all the information and support pertaining to the surgical procedure that is to take place. It is essential that all the risks of the procedure are also discussed with the patient beforehand to lower down the anxiety levels. Preoperative preparations comprise of various nursing activities that consist of the collection of data by conducting an assessment of the patient's condition, providing emotional support, post operative care and having a clear flow of communication with the patient. Make use of the SBAR communication method while interacting with the patient. The following nursing interventions are suggested while treating Mrs. Audrey as she is very anxious and is constantly asking about the well being of her dog, as she is afraid nobody will be there to take care of him.

a. Attentive listening.
b. Provide all the necessary information pertaining to the procedure.
c. Solicitation of the patient's anxiety.
d. Provide reassurance and emotional support at all times.
e. Administer an enema a night before the scheduled surgery as it helps in cleansing the colon.
f. The operative area of the skin should be prepared to free it from any microorganisms.
g. The patient should be helped to bath or shower to lower the risk of infection and to maintain hygiene. Also it could be days before the patient could be allowed to have a real bath.

Answer 5

The immediate nursing interventions that will be implemented when Audrey returns to the ward at 2000 hrs are as follows:

Post operative nursing considerations:

The patient could be at the risk of the following:

a. Alteration with respect to their ABC pathway, it comprises of hypertension and the patient has a past history of hypertension.
b. Urinary incontinence
c. Nausea
d. Neurovascular deficit
e. Risk of infection
f. Unable to maintain hygiene
g. Deep vein thrombosis or PE
h. Problems in gaining mobility
i. Further or fractures that could occur in the future as the patient suffers from osteoporosis
j. Development of pressure ulcers.
k. Constipation
l. Pain that is unresolved.
m. Nutritional deficit.

Risk	**Intervention**	**Explanation**
1. Pressure ulcer	1. Usage of polyurethane	Reduces the friction and shear

	foam dressing. 2. Usage of a pressure relieving mattress.	that the wound area is subjected to. Helps in reducing the skin area from excessive exposure to moisture (Burns et al., 2014).
2. Constipation	Emphasis on privacy and access to a toilet. Avoid long time period of fasting Encourage usage of fluids. Usage of laxatives.	Can cause problems in mobility if not monitored.
3. Risk of unresolved pain.	Usage of pain relievers. Start with paracetamol and go on to stronger drugs if needed opiods and nerve blocks.	Mobility
4. Nutritional Deficit	Reduce fasting period. Intake of minerals and vitamins	Cause weakness and fatigue hence an optimum balance needs to be maintained.

Also care needs to be taken that the patient is attended to at all times, pain medication is considered for pain management, usage of pressure relieving mattresses should be done so that pressure ulcers are not formed. The diet of the patient should be looked into so that the patient has optimum healing.

Answer 6.

10 days after the surgery, Mrs. Audrey Smith will be sent to a rehab facility however prior to this transition it is imperative to ensure that the patient can adjust and adapt to the new changes that will be taking place in the times to come. Mentioned below are 4 nursing interventions that will be implemented during this transition phase for Audrey.

Nursing intervention	Rationale	Outcomes

1. Provide encouragement to the patient to express her concerns about care at the rehab facility. At the same time be sure to explore various solutions for the patient's problems.	The patient could have certain problems in movement after the surgery hence it is imperative to clearly identify the problems so that the appropriate solutions could be put to use.	a. The rehab facility should be easily accessible to the patient when she is discharged. b. The patient should be less anxious and relatively calm. Should be able to devise strategies to deal with the problems. c. Personal assistance is available at all times. d. The patient complies with the medication and therapeutic regime that has been prescribed.
2. Check the availability of the assistance for various heath care related activities and assistance specifically for ADL'S	Due to the lowered rate of mobility because of the fracture the patient will need help in ADLs and during routine activities. So that the patient can go about doing their daily activities (Arnadottir, 2017).	
3. Teach the patients' assistances the specific health care regime that	Having a complete understanding of the rehabilitative regiment is very	

needs to be followed.	essential for complete compliance.	
4. The patient should be advised upon post hospital care: a. The limitations while undergoing various activities. b. The exercise instructions should be reinforced. c. Safety while usage of ambulatory aids. d. Caring for the wound. e. Healing measures that comprise of nutrition and wound healing. f. Medications g. Problems that could arise. h. Health care supervision.	It is essential to have complete knowledge about the health care regime that needs to be followed while in rehab. As lack of knowledge could cause anxiety to the patient along with non adherence and compliance to the medication and therapeutic regime.	

Conclusion

The paper has analyzed the care that needs to be provided to Mrs. Audrey for a quick recovery. However nursing care is not just limited to surgery and the trauma that takes place it also addresses the deficits that are present in the patient's health in the long run. Elderly patients are more prone to mal-nourishment and tend to have low hemoglobin. It is essential to monitor the dietary deficiencies so that proper wound healing can take place. Along with managing the strains that it causes to mobilization. The above mentioned interventions need to be followed for effective rehabilitation.

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